Your Group Plan

The Department of Defense
Nonappropriated Fund Health Benefits Program

Stand Alone Dental PPO

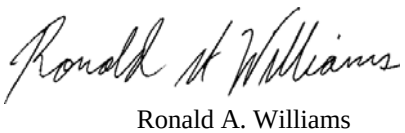
Table of Contents

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.



Ronald A. Williams
Chairman, Chief Executive Officer, and President

Group Policy: GP-620387
Cert. Base: 1
Issue Date: October 19, 2007
Effective Date: January 1, 2008

This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.

0020

Summary of Coverage

Employer: The Department of Defense
Nonappropriated Fund Health Benefits Program

Group Policy: GP-620387

SOC: 1A

Issue Date: October 19, 2007

Effective Date: January 1, 2008

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This Summary of Coverage may be an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Your Coverage

You are in an Eligible Class if you are not enrolled in a Department of Defense Nonappropriated Fund medical plan (including an HMO) and dental plan linked to such medical enrollment and are:

- a Regular Full-Time (RFT) or Regular Part-time (RPT) civilian employee scheduled to work at least 20 hours per week, who is paid on the U.S. dollar payroll, and who is a U.S. citizen or resident alien living within and outside the United States.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you commence active work for your Employer or, if later, the date you enter the Eligible Class.

The following groups are not in an Eligible Class:

- Flexible employees
- Foreign Nationals
- Resident Aliens living outside of the U.S.
  (unless he or she is a military spouse accompanied by a sponsor stationed at a location outside the United States).
- Retirees

Dependents

You may cover your:

- **wife or husband, including a common-law wife or husband in those states that recognize common-law marriages.**
- **unmarried children under 19 years of age.**
- **unmarried children under age 25 who are full-time students in actual attendance at an accredited educational institution, are not working on a regular full-time basis, and depend on you for support.**
- **any child over the maximum age who is determined to be incapable of self-support due to a handicap. Proof of handicap must be submitted to Aetna no later than 31 days after the maximum age is reached. See Child With Disabilities section.**

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren who either live with you or are dependent upon you for support.
- Any other child who is not your biological, adopted, or step child, but who lives with you and is dependent upon you for financial support. Evidence proving dependency is required in the form of documentation of legal guardianship or inclusion of the child on your income taxes.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Your enrollment packet will include a form to complete. Enrollment in the plan may be processed electronically (for the NAF services with electronic capabilities) or with an enrollment form. This form will allow your Employer to deduct your contributions from your pay to cover your contributions for the plan you elect during enrollment.

IMPORTANT! You must sign, date and return the completed enrollment form to your Human Resources Manager **WITHIN 31 DAYS** of your Eligibility Date for you and your dependents to be covered. **If you don't sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you may not elect Dental Expense Coverage until the next open enrollment period established by your Employer. If you enroll electronically (for the NAF services with electronic capabilities), your enrollment must be processed within 31 days of your Eligibility Date.**

If you want DEPENDENT coverage for a newly eligible dependent (for example, you get married or have a baby), complete a new enrollment form (available from your Human Resources Manager) or process electronically (for the NAF services with electronic capabilities) within 31 days of the Eligibility Date (i.e. date of marriage or baby's date of birth). When you elect DEPENDENT coverage, you must list all their names on the appropriate section of the enrollment form. **If you do not request DEPENDENT coverage within 31 days of the Eligibility Date, you may not elect Dental Expense Coverage for such dependent until the next open enrollment period established by your Employer.**

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed group coverage enrollment form to your Human Resource Manager or the date your enrollment is processed electronically.

If you do not sign and return your form or request to be enrolled within 31 days of your Eligibility Date, you will not be able to elect coverage until the next open enrollment period established by your Employer.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions.

If you have EMPLOYEE COVERAGE ONLY and you request DEPENDENT coverage for a *newly eligible* dependent **within 31 days** of their Eligibility Date, the effective date of DEPENDENT coverage is the date of the election.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits the election of coverage until the next open enrollment period will not apply to a child who meets the definition of a dependent and for whom you are required to provide dental coverage as the result of a qualified medical child support order (QMCSO). Upon receipt of a QMCSO, coverage of the child is not optional; your employer is required to enroll the child in the plan whether you request the enrollment or not. This coverage is mandated by the terms of the QMCSO. If your enrollment in the plan is required in order to provide dental coverage for the child, your employer will also enroll you. Coverage will be effective on the date of the court order. If you are currently not enrolled and are eligible for coverage in the dental plan, your employer will enroll you and your dependent(s) for family coverage as of the date on the court order.

If you are the non-custodial parent, proof of a dental benefit claim for the dependent child may be given by the custodial parent. Benefits for a claim will be paid to the custodial parent.

Dental Expense Coverage

Employees and Dependents

Your Booklet-Certificate spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet-Certificate for a complete description of the benefits payable.

Recognized Charge Percentage: The charge determined by Aetna on a semiannual basis to be in the 95th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

Allowable Variation	$ 10.00

Comprehensive Dental Expense Coverage

Calendar Year Deductible
The Calendar Year Deductible applies to all expenses except Type A Expenses or Orthodontic Treatment Expenses.

Individual	$ 100
Family of 2 Deductible Limit	$ 200
Family of 3 or more Deductible Limit	$ 300

After the deductible, the dental expense benefits payable under this Plan in a calendar year are paid at the Payment Percentage below. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide dental services or supplies at a Negotiated Charge. For a copy of the Directory, which lists these dental care providers call Member Services at the number on your I.D. card or go online to www.Aetna.com.

Payment Percentage	
Type A Expenses	100%
Type B Expenses	80%
Type C Expenses	50%
Orthodontic Treatment	50%
Calendar Year Maximum	$ 2,000
Orthodontic Lifetime Maximum	$ 1,500

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE

Dental Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

0740, 7669, 7672

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet-Certificate.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be $ 200 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts.

Some services may be given before Advance Claim Review is made. These are oral exams, including prophylaxis and x-rays and treatment of any traumatic injury or condition which:

- occurs unexpectedly;
- requires immediate diagnosis and treatment; and
- is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Note

As a part of Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person at its own expense.
- You must give Aetna all diagnostic and evaluative material which it may require. These include x-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage which applies to:

- Type A expenses;
- Type B expenses;
- Type C expenses; and
- Orthodontic Treatment.

3000, 3010, 7673, 11490-3

The benefits payable for charges made by a **Preferred Care Provider** is an amount equal to the Payment Percentage of the **negotiated charge** for the service or supply, after any applicable deductible.

The benefit payable for charges made by a provider that is not a Preferred Care Provider is an amount equal to the Payment Percentage of the Covered Dental Expense, after any applicable deductible.

The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. You are responsible for the deductible.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- necessary; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

This Dental Care Schedule includes only services in the list below.

Alternate Treatment

The next sentence applies if:

- a charge is made for an unlisted service given for the dental care of a specific condition; and
- the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

Here is a list of Covered Dental Expenses.

Type A Expenses
100% - Not subject to Calendar Year Deductible

VISITS AND X-RAYS

- Office visit during regular office hours, for oral examination
  Routine comprehensive or recall examination (limited to 2 visits every year)
  Problem-focused examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to one course of treatment per year and to children under age 15)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 18)
- Bitewing X-rays (limited to one set every 6 months)

- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical x-rays (single films) (up to 13)

Type B Expenses
80% - Subject to Calendar Year Deductible

VISITS AND EXAMS
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

X-RAY AND PATHOLOGY
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

ORAL SURGERY
- Extractions
  - Exposed root or erupted tooth
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury

PERIODONTICS
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant
- Root planing and scaling – 1 to 3 teeth per quadrant
- Gingivectomy per quadrant
- Gingivectomy, 1 to 3 teeth per quadrant
- Gingival flap procedure, per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Periodontal maintenance procedures following active therapy
- Localized delivery of chemotherapeutic agents
- Osseous surgery (including flap entry and closure) - per quadrant
- Osseous surgery (including flap entry and closure) – 1 to 3 teeth per quadrant
- Soft tissue graft procedures

ENDODONTICS
- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy, including necessary X-rays
  Anterior
  Bicuspid
- Root canal therapy, including necessary X-rays
  Molar

SPACE MAINTAINERS *Includes all adjustments within six months after installation.*
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

RESTORATIVE DENTISTRY *Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)*
- Amalgam Restorations
- Resin Restorations
- Sedative Fillings
- Pins
  Pin retention - per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  Prefabricated stainless steel
  Prefabricated resin crown (excluding temporary crowns)
- Recementation
  Inlay
  Crown
  Bridge

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION *(only when provided in conjunction with a covered surgical procedure).*

Type C Expenses
50% - Subject to Calendar Year Deductible

RESTORATIVE *Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.*
- Inlays/Onlays - Metallic or Porcelain/Ceramic
  Inlay, one or more surfaces
  Onlay, two or more surfaces
- Inlays/Onlays – Resin-based Composite
  Inlay, one or more surfaces
  Onlay, two or more surfaces
- Labial Veneers
  Laminate-chairside
  Resin laminate - laboratory
  Porcelain laminate - laboratory

- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
- Post and core

PROSTHODONTICS

- Bridge Abutments (see Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable Bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture
  - Complete lower denture
  - Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than six months after installation
- Full and Partial Denture Repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only) limited to 1 every 3 years

ORTHODONTICS - 50% - Not subject to Calendar Year Deductible

- Comprehensive orthodontic treatment
- Interceptive orthodontic treatment
- Limited orthodontic treatment
- Post treatment stabilization
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

3010, 3010-1, 3010-2, 3010-3, 3010-4, 3020

Special Provisions for Orthodontic Treatments

Coverage for **orthodontic treatment** is limited to those services and supplies listed on the Dental Care Schedule that applies.

A **dentist's** charges for services and supplies for **orthodontic treatment** are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for **orthodontic treatment**.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

1340-2, 3030, 3050-3

Explanation of Some Important Plan Provisions

2620, 2630

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

3040

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

2620, 2630

1340-2, 3050-3

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

3040

Limitations

3050

Alternate Treatment Rule

If more than one service can be used to treat a covered person’s dental condition; Aetna may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
the service selected must meet broadly accepted national standards of dental practice.

Replacement Rule

The replacement of; addition to; or modification of:

existing dentures;
crowns;
casts or processed restorations;
removable denture;
fixed bridgework; or
other prosthetic services

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast, or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

1340-2, 3050-3

Exclusions and Limitations

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part:

  under any other part of this Plan; or
  under any other plan of group benefits provided by your Employer.

- Those for services and supplies to diagnose or treat a disease or **injury** that is not:

  a non-occupational disease; or
  a non-occupational **injury**.

- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.
- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for:

  dentures;
  crowns;
  inlays;
  onlays;
  bridgework; or
  other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.

- Those for any of the following services:

  (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
  (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

- Those for services intended for treatment of any **jaw joint disorder**; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for **orthodontic treatment**; except as specifically provided.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with another **necessary** covered service.
- Those for treatment by other than a **dentist**; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a **dentist**.
- Those for a crown; cast; or processed restoration unless:

  (a) it is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  (b) the tooth is an abutment to a covered partial denture or fixed bridge.

- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

1330-1, 3050-1, 3060, 3070

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information section.

Dental services given after the covered person's coverage terminates are not covered. However, ordered inlays; onlays; crowns; removable bridges; cast or processed restorations; dentures; fixed bridgework; and root canals will be covered when ordered; if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means that prior to the date coverage ends:

As to a denture:

impressions have been taken from which the denture will be prepared.

As to a root canal:

the pulp chamber was opened.

As to any other item listed above:

the teeth which will serve as retainers or support; or
which are being restored; have been fully prepared to receive the item; and impressions have been taken from which the item will be prepared.

1350-1, 3070, 3070-1

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans - Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided in your Booklet-Certificate.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.

5000, 7409, 7410, 7411, 9341, 7665

- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or

  in the next calendar year.

  Facings on molar crowns and pontics will always be considered cosmetic.

1330-1, 3050-1, 5000, 7409, 7410, 7411, 9341, 7665

- Those to the extent they are not **recognized charges**, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the **recognized charge** for that service or supply by more than the amount or percentage specified in the Summary of Coverage as the Allowable Variation.

5000, 7409, 7410, 7411, 7549, 9341, 7665, 7665-1

- Those to the extent they are not **reasonable charges**, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the **reasonable charge** for that service or supply by more than the amount or percentage specified in the Summary of Coverage as the Allowable Variation.

5000, 7409, 7410, 7411, 9341, 7665, 7665-1

- Those for a service or supply in excess of such provider's **Negotiated Charge** for that service or supply.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

5000, 7409, 7410, 7411, 9341, 7665

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

9361, 9362

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

9363

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

9364

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen dental coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Dental Expense Coverage on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan providing dental coverage, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change dental coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change dental coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change dental coverage after 31 days, coverage will take effect only if and when Aetna gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

7312

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

5090

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

6051

Appeals Procedure

The following Appeals Procedure section applies only to Group Dental Coverage.

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service or supply or benefit.

Such Adverse Benefit Determination may be based on, among other things:

- The covered person's eligibility for coverage;
- The results of any Advance Claim Review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not Medically Necessary.

Appeal: A written request to Aetna to reconsider an Adverse Benefit Determination.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Post-Service Claim: Any claim that is submitted for completed services.

Urgent Care Claim: Any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

11600

Claim Determinations – Group Dental Coverage

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 1 business day of the earlier of the receipt of the additional information or the end of the 48 hour period given the claimant to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Post-service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal for certain adverse benefit determinations.

You have 180 calendar days with respect to Group Health and claims following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted in writing and should include:

Your name;
Your employer's name;
Member ID on your ID card;
A copy of Aetna's notice of an adverse benefit determination;
Your reasons for making the appeal; and
Any other information you would like to have considered.

Send in your appeal to the address shown on the notice of Adverse Benefit Determination, or call in your appeal using the toll-free number telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

If You have any questions about Your appeal or the health care services that have been provided, which have not been satisfactorily addressed by the Plan, You may contact the Office of the Managed Care Ombudsman for assistance at the following address, telephone number, e-mail address or internet site:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
E-mail: ombudsman@scc.virginia.gov
Internet site: www.scc.virginia.gov

Level One Appeal – Group Health Claims

For Utilization Review

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Urgent care claims
Aetna shall issue a decision within 1 business day of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

For Other Than Utilization Review

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Urgent Care Claims
Aetna shall issue a decision within 1 business day of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level Two Appeal (For Other Than Utilization Review)

If Aetna upholds an adverse benefit determination at the first level of appeal, and the reason for the adverse determination was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination will be reviewed by a Professional Dental Consultant not involved in making an adverse benefit determination.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

11600

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **dentist,** selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

You have received notice of the denial of a claim by Aetna; and
Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational; and
The cost of the service or treatment in question for which you are responsible exceeds $500.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review.

You must submit the request for an external review to the Virginia Bureau of Insurance within 30 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

For more information about the External Review process, call the toll-free Customer Services telephone number shown on your ID card or the Virginia Bureau of Insurance.

11600

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Employer for this definition.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

6080

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued a personal medical conversion policy.

11048

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

11048

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

6450

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at Aetna's expense.

7671

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

6470-1

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

6470

Assignments

Coverage may be assigned only with the written consent of Aetna.

6430

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.

9352

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

6320

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

6320

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

6320

Payment of Benefits

6350, 9265

Benefits will be paid as soon as the necessary proof to support the claim is received.

6350, 9265

All benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

6350, 9265

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

7693

Aetna may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

6350, 9265

Records of Expenses

Keep complete records of the expenses of each person. They will be required when claim is made.

Very important are:

Names of **dentists** who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

6380

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

9990

Dentist
This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory
This is a listing of all **Preferred Care Providers** for the class of employees of which you are a member. Copies of this Directory are given to your Employer to give to you. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Hospital
This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

Jaw Joint Disorder
This is:

- a Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint; or
- a Myofacial Pain Dysfunction (MPD); or
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Necessary
A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician
This means a legally qualified physician.

Preferred Care Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

R.N.
This means a registered nurse.

Recognized Charge
Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply.

In determining the recognized charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the recognized charge in other areas.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for dental expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days and still want the coverage, you will need to enroll in the plan during the next Open Enrollment Period.